patient know that, by and large, impotence and frigidity are curable disorders. The therapist's line of questioning ought to go in the direction of finding out if some recent event started the difficulty (if so, perhaps simple catharsis about the recent event might uncover the unconscious need to be frigid or impotent) or if perhaps lack of education and timidity are at the bottom of the trouble and might be dealt with by education and reassurance. One should be very careful, however, about complicating matters by proceeding too deeply and too quickly with these patients. In general, if the problem has existed for a long time and there is great reluctance to talk about it, referral to a psychiatrist would seem the best course. The way to do this, however, is not to make it a matter of life and death, for that will frighten the patient. In cases of frigidity and impotence which are of only recent development and the patient is not reluctant to talk, a general physician might well encourage him to talk and see whether this talk and the education the physician can give is helpful. Patients who do not respond in a few months should be prepared and educated for seeking psychiatric consultation.

**Obesity**

In my opinion obesity has become a national problem. In America we tend to overeat, overdrink, oversmoke and overtalk. It seems as though we are becoming a rather orally fixated nation. There are different kinds of emotional obesity problems and we ought to distinguish between benign obesity and the more severe forms of emotional obesity. The severe forms are certainly not in the province of general physicians and are extremely difficult to treat even for the most skillful specialists. The severe forms are those in which overeating has become an addiction and alternates with bouts of deep depression and has led to severe impairments in major fields of endeavor.

The more benign obesity problems can be dealt with by general physicians. Many persons constantly overeat, as a form of consolation for some recently experienced disappointment or frustration. It may be noted that some persons will overeat after an unhappy love affair or blow to the self-esteem. Getting them to recognize this connection can be helpful. It is wise of course to make sure that obesity does not stem from organic factors before delving into the emotional elements. As to obesity in a patient who consults a physician for something else, there is little that can be done about the excess of weight unless he becomes interested in the problem and wants to do something about it.

436 North Roxbury Drive, Beverly Hills.

# Psychosomatic Medicine

**LEO RANGELL, M.D., Los Angeles**

I SHOULD LIKE to begin by first highlighting some of the theoretical considerations relevant to the dynamics of the psychosomatic process, then to follow this with an excursion into some typical clinical examples, and finally a consideration of certain practical applications.

The human impulse, seeking discharge, may find one of three alternate paths: It can be discharged into action, that is, the person *does* something; or into affects—the discharge is into the *interior* of the organism and the person *feels* something; or into thought, in which the impulse is partially bound and partially discharged, but at any rate dealt with in a certain way, and the person *thinks* something. These are in the main the derivative end-products of instincts with which we deal in our daily efforts to assess a human being, his thoughts, his actions and his feelings.

In the situation of psychic conflict, such as prevails at the core of any neurosis, there are specific defenses against the impulses, with attendant inhibitions of discharge, from which various distortions and resultant end-products can obtain. These can be either directed externally, resulting in abnormal external actions of various degrees and types, which constitute the *behavior* problems discussed elsewhere in this symposium, or the effects can be internal. Of the latter, there may eventuate, from this internalization, some kind of abnormal mental phenomenon, such as a compulsion or an obsession, or a pathological affect or mood such as a depression; or what might result is a pathological end-product in the somatic sphere. It is this last eventuality which comprises our focus of interest—the psychosomatic sequelae of neurotic conflict.

It is well to point out that the term *psychosomatic* implies a duality which in fact does not exist, for there is in reality no small and discreet group of somatic diseases psychically induced, but rather a spectrum of diseases, with both organic and psychological factors operative in all, but more of one or the other at each end of this spectrum. Thus, in one of the definitive papers written on this subject in 1945, Otto Fenichel uses the word *so-called* (psychosomatic phenomena) in the title, pointing to and correcting this inconsistency and loose usage. Although there is this spectrum, with organicity and psychogenicity at each end, one is hard put to think

From the Department of Psychiatry, School of Medicine, University of California at Los Angeles.

Presented as part of a postgraduate seminar by the Southern California Psychiatric Society and the General Practice Section of the Los Angeles County Medical Association.

Submitted January 22, 1958.

of a "pure" example of either. As a possible contender for a purely organic lesion one might think, for example, of tumors, and yet much recent work and many individual clinical experiences lead one to withhold final judgment in this regard. Actually all disease is a combination, to varying degrees, of the psychologic and the somatic. The most "organic" disease has not only its psychic reverberations, that is, somatopsychic *effects,* but also is enhanced and facilitated by a preexisting psychological soil, while the most predominantly psychogenic disturbance has its somatic accompaniments. Selye, for example, in describing the nonspecific and common background of all diseases, gives due place to the role of psychological stress in the series of all stressor agents.

The psyche affects the soma, which in turn affects the psyche, completing the circle. Emotions cause obesity, which in turn disturbs the emotions. Even in the most physical "accident," with its resultant fractures or lacerations, proper consideration must today be given to the role of "accident-proneness" and the preexisting emotional turmoil which serves as a precursor. In a similar vein, resistance to infection, both of the specific or nonspecific varieties, varies with and is influenced by the emotional state. Thus, a sore throat can take hold in a "nervous" or run down condition, and tuberculosis may finally take pathological root in a masochistic, self-destructive person who has found no other way out of deep-seated emotional conflict.

As psychological *effects* or sequelae of organic disease, one can think for example, as a representative of this, of the reaction to a cut, when, in predisposed persons, acute anxiety, panic, actual fainting or even shock may occur. These psychologic effects range from the sequelae of such an acute instance to the most chronic of organic illnesses, where again the influences on the total being and personality of the sick person must be taken into account. Much attention, for example, has recently been paid to the handling of the dying patient, with a growing realization that it is not only the physical state of the fatal and significant organic lesion which must be treated, but the effects upon and the attitudes of its host, the patient.

Similarly, and to complete the circle, every "psychogenic" affliction has its somatic accompaniments. Thus, for example, the most "pure" psychogenic hysterical conversion has both the factors of somatic compliance as well as of somatic accompaniments. The psychic conversion is to a somatic *locus minoris resistantiae;* and an arm hysterically paralyzed is nevertheless a member in which there are organic changes and findings in muscle tonus, in the general vasomotor state, in the autonomic innervation, in sensations and perhaps in skin temperature. Thus all disease is both psychic and somatic, just as Selye has shown in an analogous and parallel way that all disease has both a nonspecific background and a specific outward form.

In pursuing further the technical delineation of the psychosomatic process, it is necessary for the diagnostician to make a differentiation between two major groups which are seen in practice. In one of these the somatic involvement confronting the practitioner is basically an hysterical process, while only in the other is it what we call more technically psychosomatic illness or an organ neurosis. The finer meanings and implications of this differentiation are of more concern to the psychiatric specialist, but a few of the major determinants will be appropriate in this discussion.

In the hysterically afflicted somatic area, the affected part is speaking in body language, symbolically, expressing a repressed idea, thought or wish. While an organic function is utilized, no organic "lesion" is involved or at most this is very secondary, incidental and not a primary part of the picture. Thus, for example, an hysterically vomiting woman may essentially be expressing the repressed wish, "I am pregnant." While there may be spasm or accompanying changes of tonus, these are incidental, and there is no such process as ulcer, but it is rather the symptom, the vomiting, which is the main thing. An hysterical convulsion with no localized disease of the brain may express an orgasm, and an hysterical blindness may give voice to the thought "I do not wish to see what is forbidden." An hysterical abasia may be the equivalent of an agoraphobia and may express the prohibition to go into a forbidden or sexually dangerous place. Pseudocyesis is another obvious example which would belong in this group. Although the patients in such cases present somatic fronts, they are hysterical rather than technically psychosomatic, and should thus be known by whoever is called upon to evaluate them. The treatment here is directed wholly to the psychic state, with the presenting somatic involvement generally requiring no local ministration. We do not treat the eye of the hysterically blind, but the mind for the conflict which lies behind it. The mechanism in symptom formation by which the leap occurs from the psychic to the physical remains obscure.

In contrast, what we technically and more specifically term psychosomatic illness, or "organ neurosis" as it is known to the psychiatric or psychoanalytic specialist, has quite another dynamic background. The somatic change here is a more real and localized one, is not symbolic, does not speak in body language, and has no specific psychological meaning of its own, but is rather a physical result of a chronic and long standing disorder in function. Thus, for example, a chronically rasping voice from

high pitched anger and from a literally snorting attitude can eventually result in chronic hoarseness or sore throat, as can a nervous or imitative cough after some time. The true psychosomatic disease is brought about by such mechanisms. In this way, for example, hypertension can ultimately result from chronically repressed anger, or an ulcerated duodenum can eventuate as a result of long-standing hypersecretion and chronic gastric contractions expressing the desire to take in love and nourishment. Neither the blood vessels nor the gastric mucosa speak symbolically in these instances, but are rather the physical evidences of breakdown as a result of the long-standing frustration and undischarged or unfulfilled tensions. In this group, while the psychic background must certainly come in for its share of basic treatment, obviously the localized somatic area must similarly be attended, oftentimes in an emergency way. The latter, for example, obtains in the case of a hemorrhage from an ulcer or in the sometimes serious acute state produced during the course of ulcerative colitis.

This second category, that of the truly somatic sequelae of psychological stress, may be seen upon closer observation to consist microscopically of a number of intermediate steps. Thus certain of the presenting symptoms may be affect-equivalents, or the physical manifestations or accompaniments of otherwise unexpressed affects. Cardiac neurosis, for example, with its palpitation and arrhythmia and changes in respiratory rate and rhythm may constitute the vascular accompaniments of anxiety. The latter may not be consciously felt or recognized, but the cardiorespiratory signs may be the only things which point to it. In such a condition of dammed-up or strangulated affects, whether of latent anxiety, rage or other emotion, there is tension, irritability and an unconscious readiness for affects, which can be set off with minimal stimulation.

It is obvious how a neurotic tension state of this sort would bombard its effects on the endocrinologic systems, both qualitatively and quantitatively, as well as on the sympathetic and parasympathetic nervous systems with their consequent physical sequelae. In the final stages there ultimately come to pass the physical results of such unconscious attitudes or unconscious behavior patterns, producing their chronic and visible somatic effects. It is in such a way, for example, that a habit of clearing the throat, or of sleeping with the mouth open, can come to bring about pharyngitis. Unconscious motivation is sometimes intuitively perceived. An irate wife recently berated her husband with, "Who are you snoring at; me?"

Consider, as another illustrative example, the state and characteristics of the muscle tonus, as this may reflect and reveal unconscious determinants. A person who characteristically represses and blocks discharge may show a rigid muscular stance and posture. In one such patient, a process was observed in statu nascendi whereby a long and characteristic period of rigid and tense posture, with muscular tightness, clenching of the fists, stiffening of the back and entire trunk, and frequent contracting and flexing of the muscles, all expressive of severe aggression and defensive control, was finally followed by the onset of an ascending arthritis of the spine which was then diagnosed by an orthopedist as Marie-Strümpell syndrome. Another reaction may be a hypotonia in a person who is spineless and submissive; or, as still another variant, alternating hypertonia and hypotonia may result in the picture of a psychogenic dystonia, or I believe actually of a scoliosis. Or muscular fatigue may be the equivalent of depression.

The foregoing are some of the dynamic mechanisms and transitional phases in the genesis and development of the psychosomatic process. Most individual syndromes, however, are frequently combinations of several factors, and are multidetermined, the end results of more than one dynamic, etiologic stream. Thus, as an example, a case of ulcerative colitis may combine multiple psychic determinants in one. The resultant end lesions may on the one hand be the culmination of long-standing eliminative or retentive pressures. At the same time, however, the symptoms may symbolically express repressed impulses toward the outside world, impulses of aggression, or impulses to destroy, or to depreciate, or for that matter the opposite, in that the same diarrhea may express generosity, or the impulse to give, whether love or material things. Simultaneously, the same symptom may constitute an equivalent of the affect of anxiety. There is in addition, of course, the necessary etiologic factor, not to be ignored, of the invading organism, which also have to be directly treated, whether by antibiotics or other means.

To turn further now to a brief consideration of some clinical examples of psychosomatic involvement, these can be seen to run through the entire gamut of the organ systems of the body, so that only a few representative specific syndromes can be selected here for mention as typical and demonstrative. Although some systems such as the gastrointestinal or cardiovascular are more frequently vulnerable and more characteristically affected as the locus of such processes, no system is excluded from such influences. Thus, for example, the musculoskeletal system may react with muscular rigidities, spasms, and then perhaps with myositis or with various types of arthritides such as in an example cited

earlier. Migraine, with its major emotional determinants, is an example of a specific type of effect on the central nervous system, as are the frequent exacerbations of many of the neurologic syndromes, such as Parkinsonism, or many of the degenerative diseases, following acute or chronic emotional stress. The genitourinary tract may present to the specialist in this field urethritis or cystitis following a long habit of psychogenically induced urinary retention. And the gynecologist may deal with pruritus vulvae or pruritus ani as a masturbatory equivalent, or may see vaginitis or cervicitis as a result of various types of masturbatory practices. And in addition to these specific and localized involvements, there is the wide and kaleidoscopic reaction type embraced in the *allergic* diseases. The emotional component is a large one among the etiologic factors in these conditions, and it is one to be looked for and reckoned with whether the ultimate expression of disease is allergic rhinitis, giant urticaria or asthma.

As an example of the organ systems characteristically involved in response to emotional stress, we may consider for a moment the cardiovascular system. The heart is notoriously a sensitive barometer of the emotional state. The organ of love, it beats fast in rage or fear, and is heavy if one is sad. Affective states produce circulatory and vasomotor responses in the forefront, through sympaticotonic or vagotonic pathways. Blushing, pallor, dizzy spells, fainting spells, anginal symptoms, or even arrythmia are among the many manifestations which may result. A physician patient whose symptom consisted in attacks of paroxysmal tachycardia and one or two episodes of actual auricular fibrillation, received analytic therapy for these and other anxiety symptoms for a period of several years, during the course of which it was noted there was considerable psychic background for these cardiac occurrences and with the resolution of the psychic difficulties the attacks were convincingly benefited. Similarly in a case of coronary thrombosis, one can hardly any longer be satisfied with explanations solely about cholesterol, body weight and other dietary factors to the exclusion of chronic background tensions, anxiety, rage and other emotional conflicts.

The question of specificity in relation to psychosomatic disease is a perplexing one. I think that we have particularly wished to find a neat classification and correlation of certain personality types with certain disease syndromes. However, surveying our general experiences thus far, in spite of the specificity described by Alexander and others and the personality profiles offered by Flanders Dunbar, I would lean toward the opinion that no convincing correlations have as yet been established, much as we would like such to be the case. Although we may select anger and rage to be dominant emotions in the constriction and narrowing of the blood vessels in hypertension, this emotion can exist diffusely in all other psychosomatic lesions as well, such as in causing the skin to be red with rage. The latter can thus express not only exhibitionism but anger as well.

While repressed hostility may play a major role in the background of ulcerative colitis and other lower intestinal or anal conditions, generosity, as noted previously, can be equally expressed by this system. Self-destructiveness and masochism can exist behind the syndrome of tuberculosis or of a coronary occlusion, but I believe it can similarly exist in any psychosomatic disease pattern, particularly of the chronic or profound variety. Similarly, anxiety either in overt or disguised form appears throughout every syndrome. While it is appealing to maintain a concept of an "ulcer type," ulcers occur in other than this classical ulcer type, and we find the hungry-for-love individual developing any one of a number of other psychosomatic manifestations without gastric or duodenal ulcer. Patently many other factors are involved, not the least of which is constitutional predisposition.

At the opposite end of the spectrum, the somatopsychic effects, or what are also called the pathoneuroses, are the neurotic sequelae of organic disease, which complete the circle and fill in the total picture of the sick person. In persons who are so predisposed, the somatic affliction may mean to them, psychically, to be abandoned or deserted or castrated, or it may pose a masochistic temptation which the patient can then seize upon and make use of. Sickness itself reduces the patient to a narcissistic state and the sick organ or the sick body as a whole assumes to itself an undue investment of interest, libido or psychic energy. Sickness may in this way come to produce problems of regression, or of infantilism or hypochondriasis or dependence. Some persons thus inclined will rush to these conditions more than others, and it is the resulting total picture which will obviously confront the healing physician and have to be considered.

These conditions might come on acutely or they might be prominent ingredients of a syndrome coming on imperceptibly with old age and senility. In either case, the total reactions of the sick patient or the older person have to be understood and actively combatted and treated by the alert physician. Secondary gain of the illness must similarly be evaluated and dealt with. There are curious individual reactions to specific afflictions which are indicative of the mental state of the host. Thus recently a patient who underwent a ventriculogram for a potential brain tumor consciously denied any anxiety about what the findings of this study

might reveal, but instead was exceedingly upset at the necessity for a haircut which removed her carefully groomed long red hair. It is obvious how denial and displacement and other mental mechanisms were operative here.

In an opposite way, it is possible for the onset of an organic disease to alleviate, at least temporarily, an otherwise disturbed mental state, resulting in what is called a "patho-cure." The physical disease may relieve guilt, or provide a needed and wanted punishment and in this way reduce a tension state to a position of equilibrium. Thus it was a common observation in Army hospitals during the last war that the patients in orthopedic wards with their visible fractures and their impressive appliances and apparatuses were among the happiest and most contented of the hospital patient population. In contrast those with more subtle and indefinable infectious, metabolic or other internal diseases still suffered from numerous anxiety and other neurotic symptoms.

A patient, for example, who had been in psychotherapy for a number of months for many mixed neurotic symptoms, alcoholism, depression, and self-destructive tendencies, was involved in an automobile accident (her husband was driving) in which she suffered severe injuries and numerous small fractures. She proved to be a most cooperative, docile, undemanding patient in the hospital, the nurses remarking about her philosophical attitude. The family congratulated themselves and the therapist (erroneously) on how far she had come in her psychiatric treatment. The fact was that the externally induced pain and suffering had temporarily made the neurotic process unnecessary and had allowed it to recede. With improvement in her physical status, the emotional symptoms returned as before and her psychiatric therapy was resumed. Similarly, the patient mentioned above with the ventriculogram and suspected brain tumor improved considerably but only temporarily in her long-standing chronic neurotic state while these investigations were in progress. As it became clear that the studies were negative, the patient's anxieties and acting-out tendencies returned.

Turning now to the treatment for psychosomatic illness, this is seen to depend on many factors and on the global picture. The psychiatric aspects of the treatment run the gamut from the briefest and most superficial of psychotherapeutic approaches to those which require the most intricate and specialized psychiatric care. Similarly, the prognosis varies through the entire spectrum, from the most transient and benign conditions to the most stubborn and disabling ones. More, even, than the presenting surface symptomatology, the general underlying character structure of the patient must be assessed and evaluated as well as the strength or weakness of his ego structure and capacities. The syndrome in question may have a temporary and transient meaning, easy to come and quick to go, or may represent even a substitute for a psychosis. Incidentally, in these last mentioned instances it is of obvious danger to radically and too quickly extirpate by dramatic means the existing somatic illness. In general, the more acute the onset and the more prominent the external factors, the better the prognosis.

Within the available armamentarium of the general physician in these cases are many methods. He may be able in favorable cases to supply the patient with a degree of insight and understanding into certain hitherto obscure mechanisms or tendencies which can help the patient to more adequately handle difficult situations. Or his therapy may rely upon his wisdom and authority, or may be effected through external measures or environmental manipulations. He may supply advice, or reassurance or may provide educational measures. In other cases various tranquilizers or ataraxic drugs may be of partial or temporary help. Incidentally, symptomatic improvement itself is by no means always proportional to the length or depth of psychiatric treatment, and sometimes the most dramatic results can occur with a very limited influence where certain dynamic factors are favorable.

One of the most generalized and severe cases of neurodermatitis I have ever seen, and which had disabled the patient for many months, melted away under the impact of two or three productive psychotherapeutic interviews. A pronounced and patent underlying neurosis was revealed, to which the patient reacted with an unambivalent refusal to go further. The psychosomatic process cleared up dramatically so that she "no longer had any need." She subsequently referred a number of other patients for psychotherapy very enthusiastically, but felt no urge for further therapy for herself.

As a general statement characterizing the psychotherapy which should be administered by physicians in general practice, one could say that this should remain above the level of defenses rather than resort to deep probing below this level. Thus, for example, it is safe and may frequently be of considerable help to instruct a patient that his physical state "is due to his emotions" or to the fact that he is nervous or upset. Such an explanation is likely to be not only new and helpful but certainly acceptable to the patient, rather than adding "upset because of death wishes, or homosexual feelings," which may not only be unacceptable but wrong, or, even if right, when applied at the wrong time and in the wrong way may very well be devastating. It

is important in these therapeutic efforts and relationships not to add to the already precarious state the factor of iatrogenic superimposition. Nor should hypochondriasis be facilitated by the physician who lightly and evasively blames this organ or that for vague and indefinable symptoms, particularly in a hypochondriacal patient who will seize upon these casual words and make the most of them. While on the one hand, it may not be desirable to uncover or to stir up, and more advisable to strengthen defenses, it is yet obligatory that the physician himself know what has happened and that he not concur with the patient in some faulty rationalization which would lead to what I have called elsewhere "a pact of mutual misunderstanding" even though the latter may temporarily and unreliably patch up for a short time the presenting symptom.

It is thus well for a general physician not to attempt specific or too deep insight therapy. I have known rather drastic results produced by a physician in the army who, upon learning some of the deeper mental complexes of man, invaded a psychiatric ward and indiscriminately informed a number of regressed patients, "You are nothing but a homosexual," or "You're just in love with your mother." This interpreter found himself subjected to rather homicidal denials. Similarly a patient's "stiff neck" might be attributed on first meeting and in early interviews to her general rigidity, or to her stiffness and tightness and fear, but not to the fact that "You are surreptitiously having an erection" which would better be left to the realm of the psychoanalyst, after he has reached such a point in uncovering the patient's deepest wishes and conflicts. Major and deep interpretation is no more within the realm of such treatment attempts than is major surgical operation in the office, or without anesthesia. Parlor psychoanalysis is no more justifiable than is wielding a scalpel in the living room. Among its complications, besides causing external havoc, can be the production of psychosis or other such untoward effects.

There are cases, of course, at the other end of the spectrum, in which the most specialized and definitive of psychotherapeutic approaches are needed and in which therefore only a long and persistent effort directed toward the most basic and primitive etiologic mechanisms can offer any promise of basic change. An example of such a clinical instance, which it might be of interest to mention and describe, was a long therapeutic experience I had recently with a young man with a history of almost life-long asthma. During the course of this treatment, many underlying and contributing psychologic mechanisms emerged, some that brought on the physical signs or symptoms, and some that represented the psychic meaning to the patient of already-present physical manifestations. All these factors were interrelated in a web or net-like fashion. Not only did the wheeze represent a crying or a passive longing for the mother, but it was also at the same time an expression and equivalent of severe anxiety. Incidentally, the wheeze was also of itself, especially when severe, a *cause* of anxiety and even fear of death. The desperate sucking in of air meant, at the deepest levels, to suck in his mother's milk, while his barrel chest cavity represented a container within which he retained milk and love and narcissistic supplies. The frequent flow of mucus represented tears and the narrowed bronchial passages expressed and paralleled his totally inadequate general line of communication to objects and people in the outside world. From dreams and other material it emerged that fluid or mucus or any extruded liquid was equated with blood, which expressed violent, murderous, revengeful thoughts against those at whose hands he had felt rejected and forlorn. His sick and tender chest cavity also represented an opening into which he would retreat when hurt and in which he periodically lived, when sick, for long periods. On other occasions, many of the weird respiratory sounds which were periodically emitted were seen, from dreams and other associations, to be the equivalent of jeering anal wind which he was directing toward his persecutors and neglectors.

Gradually, during the course of treatment, and paralleling a considerable improvement in his physical state, his tears came to flow more outwardly, from his eyes instead of from his chest. Through and concomitantly with a greatly improved communication with the outside world, a widening of the passageway for air was accomplished. Instead of internal somatic episodes there were first externally directed behavioral attacks, and finally more realistic outside action in the general life situation of the patient, in his relationships with his peers, with his loved ones and in his work. Of further special interest was the fact that simultaneously with the psychoanalytic treatment of his all-pervasive, generalized emotional disturbance there was, especially in the first part of treatment, the need for periodic topical and localized treatment of the affected pulmonary processes both by an allergist and an internist, at times with necessary emergency measures.

It is probable that many of the more transient asthmatic episodes observed quite frequently in medical practice come about in a way similar to that in the foregoing case but by mechanisms less profound, and without the permanent crystallization to one deeply involved system. One can apply similar studies and methods of thought perhaps to allergic disease in general, whichever system they may involve.

It is likely that material like the foregoing is quite unfamiliar to physicians who do not customarily

deal with such unconscious mental processes, and no doubt is difficult to absorb with any degree of conviction without further documentation. Nevertheless, although documentation cannot be given here to any appropriate degree, this brief extract is offered in the hope that it does give an idea of the kind of deep emotional conflicts which may be expressed and of the complex interrelationships which exist between psychic and somatic processes. It is to be reiterated that treatment at this level is limited only to certain selected and advanced cases and is to be administered with the utmost care only by the qualified psychiatric or psychoanalytic specialist.

In closing, I would like to say as a general statement that while a host of emergency somatic therapies are in order in the case of a sudden perforated ulcer, or when a hemorrhage occurs in a patient with ulcerative colitis, I think we would now consider the treatment regimen incomplete without the proper institution of psychotherapy in the total rehabilitation program. Similarly, following the occurrence of coronary thrombosis, any treatment program involving diet, anticoagulants and weight reduction would be dangerously incomplete without a complete evaluation of the patient's total life situation and an attempt at reorganization which would take into account not only the multitude of physical factors which exist but also every aspect of the patient's psychic life. In many or even most cases, it is the general physician who should provide and guide this total and overall treatment program. In certain other cases, however, where the psychological contribution is more intricate, subtle or complex, or more dominant in the concatenation of etiologic factors, the treatment of this aspect of the total illness would be well given over to a psychiatric specialist.

405 North Bedford Drive, Beverly Hills.